Onondaga Hill Chiropractic 315-469-7791

Patient Name_________________________________DOB________________Date___________

Marital status: [ ] single [ ] married [ ] divorced [ ] widowed [ ] other

Medication #1 – Please list 1.) Medication NAME, 2.) STRENGTH, 3.) DOSAGE instruction.

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Race: __________________ Ethnicity: ____________________ Language: __________________

Are you allergic to any medications? YES NO

If "YES" please list Medication _____________________and Symptoms_________________

Have you been Diagnosed with any of the following (Circle all that apply)

Asthma, Cardiovascular Disease High/Low Cholesterol Diabetes High Blood Pressure

What is your preferred method of contact? Phone call to: Cell Home Work

Vitals: Height_____' _____" Weight_____________

Surgeries: ____________________ Date: ________________ Results: ________________

____________________ ________________ ________________

Family History: Relationship:	Problem:	Deceased:	Date:
___________________	________________________	[ ] No	[ ] Yes _________
___________________	________________________	[ ] No	[ ] Yes _________

Social History:	Smoking	Alcohol	Caffeine		Exercise
(Circle	Never smoked	None	None		Never
All that	Current Smoker	Casual	<3/day		Daily
Apply)	Everyday	Moderate	3-6/day		Weekly
	Former Smoker	Heavy	>6/day	`	Walks
					Runs
					Swims